Interim Evaluation of Health Care Coverage Initiative in California

Nadereh Pourat, PhD
Gerald Kominski, PhD
Dylan Roby, PhD
Allison Diamant, MD, MPH
Ying-Ying Meng, DrPH
Cori Reifman, MPH
Anna Davis, MPH

August 13, 2009

California Health Care Coverage Initiative (HCCI)

In August 2005, the Centers for Medicare and Medicaid Services (CMS) approved California's five-year Section 1115 demonstration waiver (No. 11-W-00193/9). This waiver provided $180 million in years 3, 4, and 5 for the development and implementation of Health Care Coverage Initiative (HCCI) programs in selected counties to expand services to low-income uninsured adults not otherwise eligible for Medi-Cal. HCCI is currently being implemented in ten counties in California, beginning September 1, 2007 and ending on August 31, 2010. The goals of the Health Care Coverage Initiative program in each county are to:

- Expand the number of Californians who have health care coverage;
- Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics, and community clinics;
- Improve access to high quality health care and health outcomes for individuals;
- Create efficiencies in the delivery of health services that could lead to savings in health care costs;
- Provide grounds for long-term sustainability of the programs funded under the initiative; and
- Implement programs in an expeditious manner in order to meet federal requirements regarding the timing of expenditures.

The UCLA Center for Health Policy Research received funding from the California HealthCare Foundation to prepare this interim report to the California Department of Health Care Services (DHCS) for use by DHCS in its application for renewal of the Safety Net Financing Medicaid Waiver.

This interim evaluation report presents data provided by the ten HCCI participating counties in quarterly and annual progress reports to DHCS to date. The reports include summary statistics and trend data by quarter for each county participating in the HCCI program. These include county-level data for the majority of counties on inpatient days, emergency room utilization, outpatient visits, enrollment and disenrollment, total expenditures, medical home assignment, outreach, and other data used by DHCS to

monitor current progress in implementing the respective HCCI programs. The progress reports also include limited descriptions of the successes and challenges faced by each participating county.

In addition, UCLA requested and received further data on delivery of certain services, including delivery of clinical guideline concordant services and changes in patient health status during program implementation. These further data submissions from specific counties are included in Appendices 12 – 15 and referenced in exhibits. The third source of data for this report is qualitative data collected by UCLA through meetings, site visits, and interviews with HCCI counties. This information includes scope of service delivery, outreach and in-reach strategies, enrollment strategies, and challenges and successes in program implementation.

This interim evaluation report is organized to address the goals of the Health Care Coverage Initiative program described above. It includes sections on expenditures, enrollment expansions, outreach activities, service expansions, utilization of health services, quality of care, system design and innovation, implementation timeline and challenges, conclusions, and recommendations for waiver renewal.

METHODS

This report incorporates data from year one and the first and second quarters of year two of the HCCI program (September 1, 2007 to February 28, 2009), although some data are only available for the first year. Data are drawn from the revised year one annual reports (quarters one through four), and from the year two, quarter three progress reports (revised quarters one and two) submitted by the counties to DCHS. For the first program year, San Francisco County did not report quarterly data, but did report annual data. Therefore, all quarterly trends for the first four quarters do not incorporate data from San Francisco County, unless otherwise noted. Similarly, the revised year one annual report for Ventura County was not available at the time of submission, and data presented on Ventura County do not reflect potential increases in first year enrollment, utilization and expenditures, as was observed in other counties' revised year one reports.

Enrollment, utilization, and expenditure data from quarterly county progress reports to DHCS were converted by UCLA into rates per 1,000 members per month to standardize the presentation of these data and to facilitate comparisons across counties regardless of the size of the county's enrolled population. HCCI counties report the number of enrollees and disenrollees in each quarter, but are not required to report the number of months of enrollment per enrollee within each quarter, which is needed for calculation of these rates. UCLA calculated the rates per 1,000 members per month by first estimating the count of enrollees in each quarter (unduplicated count of new enrollees minus unduplicated count of disenrollees) for the first six quarters of program implementation (September 1, 2007-February 28, 2009) for each county. The total number of months of enrollment accrued by these enrollees was then estimated by assuming two months of enrollment on average per quarter for individuals who newly enrolled or disenrolled during each quarter, and three months of enrollment on average per quarter for continuous enrollees. Using this estimated

total number of member months per quarter, the rates of health care utilization per 1,000 members per month were then calculated by dividing overall utilization of a given service (e.g., inpatient days) by member months for the same time period and multiplying the result by 1,000.

It is important to note that while the rate per 1,000 members per month controls for differences in enrollment or population size, it does not account for variations in program implementation or population characteristics of each county. The HCCI programs are diverse in both regards. Furthermore, it should be noted that all quantitative data presented in this interim evaluation were provided by HCCI demonstration counties in their quarterly progress reports to DHCS and are not independently verified by UCLA.

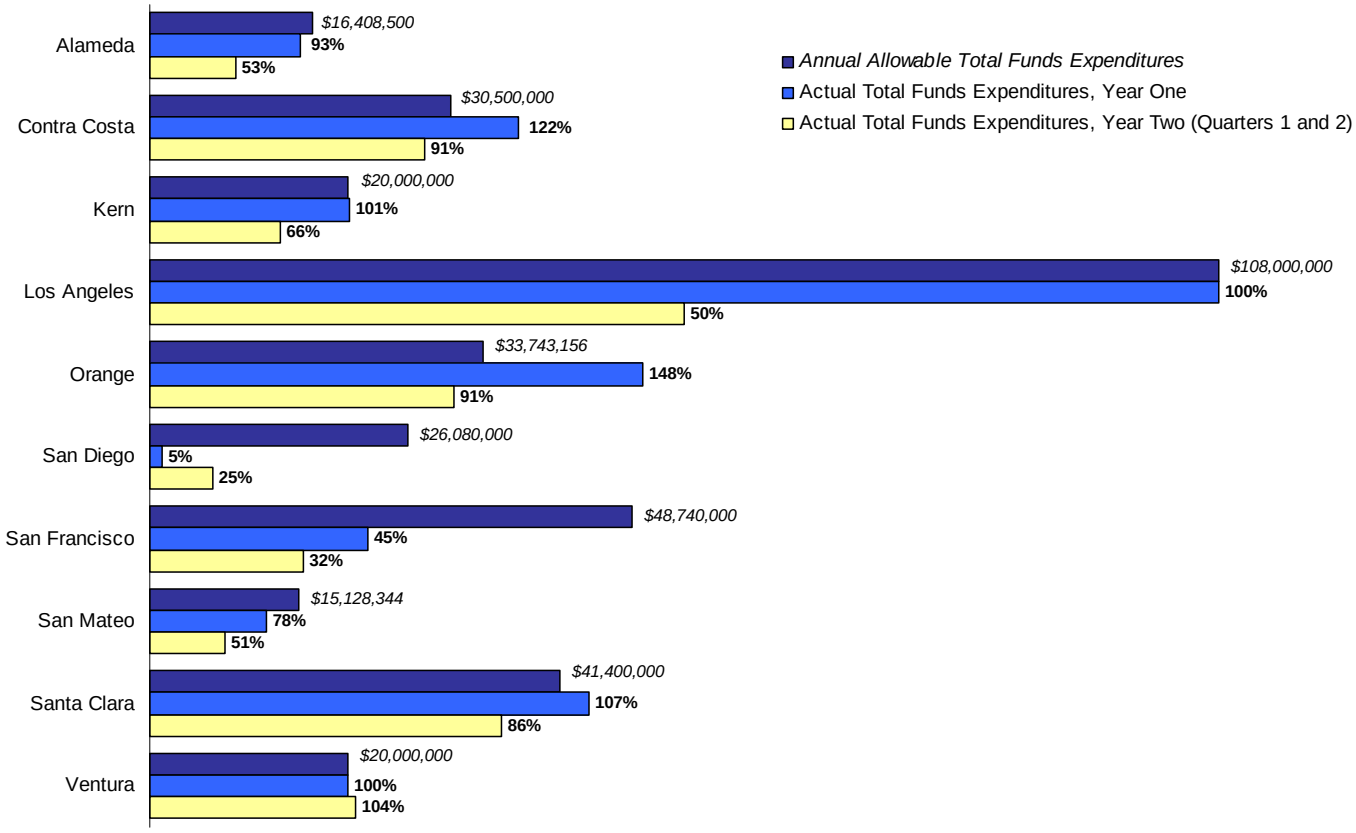
FINDINGS

Expenditures

HCCI participating counties are awarded funds for their program as specified in their respective contracts. The Allowable Total Funds Expenditures (TFEs) are the total allowable costs incurred by a county for HCCI covered services provided to HCCI enrollees under section 1115(a) *Medi-Cal Hospital/Uninsured Care Demonstration* waiver. Under the waiver, counties must expend 100 percent of TFEs using local funds to claim federal reimbursement. The counties must certify their expenditures to DHCS as Certified Public Expenditures (CPE) to qualify for federal reimbursement at the applicable Federal Medical Assistance Percentage (FMAP), currently at 61.59%.

Exhibit 1 displays the annual allowable and actual TFEs for the first year (quarters one through four) and the second year (quarters one and two). Some counties have reported actual TFEs in excess of the allowable TFEs in the first program year. DHCS is currently in the process of approving re-allocation of unexpended funds from the first year.

Exhibit 1: Annual HCCI *Allowable* and Actual Total Funds Expenditures, Including Percent of Award Expended by County; Year One and Year Two (Quarters 1 and 2)



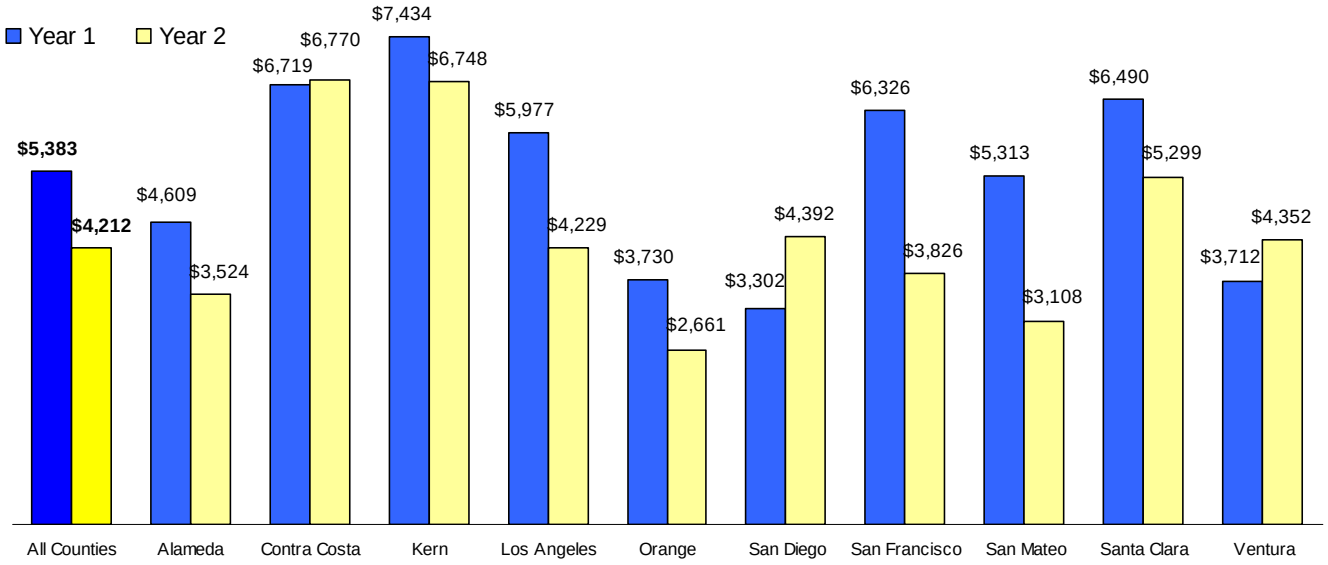
Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS; County contracts with State

During year one of the HCCI program, two counties spent 100% of allowable TFEs, four spent more than their contract allotment, and the remaining four counties spent less than

their allowable TFEs. In the first two quarters of the second year, eight counties have spent 50% or more of their annual allowable TFEs, with expenditures ranging from 25% to 104% of allowable amount (Exhibit 1). Differences in actual expenditures reflect variations in enrollment, system of care, and type of services delivered. In addition, expenditure differences in the first program year reflect delays in program implementation, enrollment, and development and approval of cost claiming methods. DHCS negotiates with CMS to determine what expenditures are allowable. Cost claiming methodologies are outlined in the *California HCCI Administrative Cost Claiming Protocol Implementation Plan.*

Annualized TFEs per enrollee are displayed in Exhibit 2. For the overall program, the annualized mean expenditure per enrollee was estimated at $5,383 in year one and $4,212 in quarters one and two of the second year (Exhibit 2). The mean expenditure per enrollee by county ranged from $3,302 to $7,434 in year one and $2,661 to $6,770 for the first two quarters of year two. The differences in expenditures per enrollee between the demonstration counties are due to multiple variations in program design and implementation, and population characteristics.

Exhibit 2: Annualized Total Funds Expenditures (TFEs) per Enrollee by County; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS

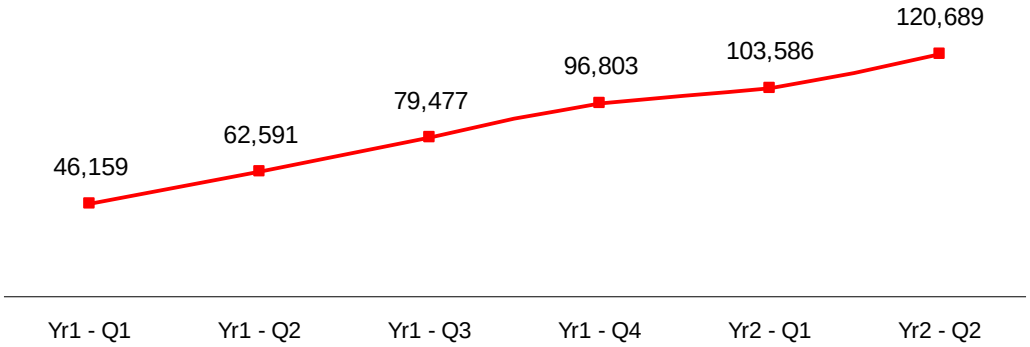
Expenditure data are subject to variations due to lags in claim submission and adjudication processes at the time of submission of these data.

Expansions in Enrollment

HCCI counties projected a total target enrollment of 167,960 in the first program year, and 168,760 in the second program year. These projections were based on county estimates of the number of eligible low-income uninsured adults in their counties. HCCI counties enrolled a total of 96,803 individuals during the first program year (58% of projected enrollment). By the end of the second quarter of year two, enrollment had reached 120,689

individuals (72% of projected enrollment). Overall HCCI enrollment has continued to increase in the time period studied and has more than doubled since the start of the program (Exhibit 3). The enrollment numbers for the second program year may be underestimated since some enrollees may not have been re-certified by the time county progress reports were submitted to DHCS.

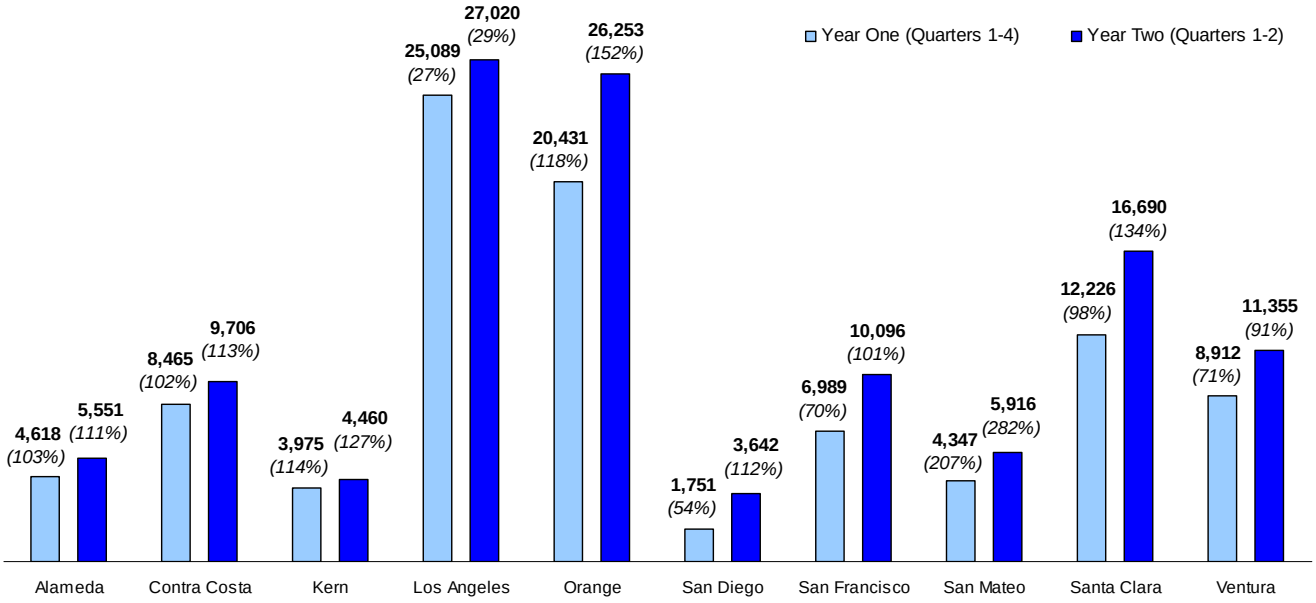
Exhibit 3: HCCI Total Enrollee Population by Quarter; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS
Note: San Francisco County quarterly enrollment is estimated based on annual enrollment

Enrollment figures by county for each year are displayed in Exhibit 4. Variations in enrollment in the first year of the project are due to the implementation processes in each county. Some counties were able to enroll quickly while others needed more time to build provider networks and other necessary infrastructure first. However, by the second year, eight counties exceeded their two-year enrollment target by the end of the first half of the second year. Two out of ten counties have not met their enrollment targets to date.

Exhibit 4: Annual Enrollment by County, Including *Percent of Target Enrollment*; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS

At the time of their proposals to the state, the counties were not aware of DRA and income-based eligibility restrictions, which were finalized early in the first year of the program. Therefore, original enrollment targets proposed by the counties were in many cases overestimates of the eligible population. Prior to contract execution, counties had the opportunity to revise their original proposed enrollment estimates given the restrictions on eligibility. However, most counties either under- or overestimated the eligible population in their region, and their ability to enroll that population in a timely manner was impacted. This may explain in part differences between estimated target and actual enrollment numbers found in some counties.

Many HCCI counties reported barriers to enrollment related to DRA requirements, particularly in the first year of the program. HCCI programs must comply with requirements of section 6036 of the Deficit Reduction Act of 2005 entitled, "Improved Enforcement of Documentation Requirements" in order to enroll eligible low-income, uninsured individuals into Coverage Initiative programs. HCCI counties are required to obtain "satisfactory documentary evidence" of U.S. citizenship and/or identity from eligible individuals prior to enrollment in HCCI. Documents that provide proof of citizenship and identity include U.S. passport issued without limitation; certificate of naturalization; or certificate of U.S. citizenship. Without one of these documents, individuals must show both a citizenship document such as a birth certificate and an identity document such as driver's license. Verification of eligibility and obtaining documentation have been a costly and time consuming tasks leading to significant delays in enrollment. Among problems were ability to identify citizenship for individuals born both in and outside California without satisfactory documentation (e.g., homeless) and those born in the U.S. but not California.

Six weeks into the first program year, counties were notified that they had to comply with the income verification requirement, requiring HCCI eligible individuals to supply proof of income below 200% FPL both at enrollment and recertification. Some counties reported loss of applicants due to this requirement, and clinic or county staff had to spend resources securing income documentation from all patients previously enrolled. In addition, eligible individuals had to supply documentation regarding prior insurance status. This crowd-out stipulation requires that individuals with an income between 101% - 200% FPL who meet other eligibility criteria "shall not have had health insurance in the three months prior to enrollment in the CI" unless the individual had employer sponsored insurance that was lost due to a loss of job, move, or similar event. Some counties also reported delays in enrollment due to this provision.

Counties resolved barriers to DRA requirements in various ways. Most HCCI participating counties obtained the California Birth Certificate Index database from the State Vital Statistics Program. Some counties, such as Alameda and Orange counties integrated the Index into their electronic enrollment programs so that citizenship can be confirmed at enrollment rather than retroactively. However, the Index database is not sufficient when patients are born outside of California. In Los Angeles County, only 7% of patients within the Department of Health Services were present in California Birth Certificate Index. To resolve this problem, Los Angeles County reimbursed clinics for the cost of ordering out of

state birth certificates. Alameda County also provided some funding to clinics to help track down birth certificates. Similarly, San Francisco County provided some assistance to potential enrollees in obtaining birth certificates and state identification.

Outreach Activities

HCCI participating counties conducted intensive outreach campaigns to eligible populations in their respective counties (Exhibit 5). HCCI counties developed and distributed informational materials, including brochures, posters, flyers, letters, banners, newsletters and handbooks. Some of the materials are produced in multiple languages, including Spanish, Chinese and Vietnamese, to reach the diverse populations eligible for the program. Eight counties have organized community events to promote the HCCI programs, reaching more than 140,000 individuals across the state. All counties have additionally conducted outreach trainings or service delivery coordination meetings.

Exhibit 5: Outreach activities conducted during of the HCCI program, Year One and Year Two (Quarters 1 and 2)

		Information material developed and distributed	Material languages	Health Promotion Events	Non-Health Promotion Events	Outreach Training/ Coordination meetings
Alameda	**Year 1**	10,900 Copies of letters and brochures	English Spanish	Not Available	Not Available	9 events 180-225 attendees
	Year 2	Not Available		Not Available	Not Available	2 events
Contra Costa	**Year 1**	1,000 Copies of 9 materials	English Spanish	40 events 1,738 participants	15 events 1,308 participants	11 events 289 attendees
	Year 2	500 copies of 4 materials		3 events 212 participants	4 events 117 participants	5 events 107 attendees
Kern	**Year 1**	5,250 Member packets 5,250 Outreach brochures 5,250 Flyers	Not Available	Not Available	Not Available	Not Available
	Year 2	5,250 copies of 3 materials		Not Available	Not Available	17 events 96 attendees
Los Angeles	**Year 1**	35,049 Brochures 169 Posters 61 Banners 60,631 Letters 3 Videos	English Spanish Korean Vietnamese	318 events 20,192 participants	479 events 28,219 participants	1018 events 3,823 attendees
	Year 2	27,390 Brochures 161 Posters 71 Banners		463 events 21,552 participants	715 events 29,993 participants	223 events 3,937 attendees
Orange	**Year 1**	19,000 Patient handbooks 10,000 Tri-fold flyers 12,000 Provider newsletters 18,000 Crowd-out letters 10,406 DRA letters 10,000 Notices of privacy practices	English Spanish Vietnamese	30 events 955 participants	11 events 12,415 participants	124 events 271 participants
	Year 2	12,000 Patient handbooks 4,000 Provider newsletters		15 events 350 participants	5 events 100 participants	2 events 18 attendees

		Information material developed and distributed	Material languages	Health Promotion Events	Non-Health Promotion Events	Outreach Training/ Coordination meetings
San Diego	**Year 1**	300 Fliers 300 Information sheets 300 Fact sheets 300 Patient guides	Not Available	26 events 130 participants	10 events 150 participants	24 events 125 attendees
	Year 2	200 copies		Not Available	5 events 75 participants	2 events 20 attendees
San Francisco	**Year 1**	1,000 Letters 1,000 Quick Guides 1,000 Program handbooks 1,000 Welcome packets 1,000 Participant newsletters	English Chinese Spanish	Not Available	25 events 500 participants	12 events 280 attendees
	Year 2	30,803 copies distributed, 6 materials		Not Available	5 events 150 participants	8 events 420 attendees
San Mateo	**Year 1**	8,000 Letters 4,400 Brochures	Not Available	Not Available	34 events 4,600 participants	24 events 1,200 attendees
	Year 2	Not Available		17 events 2,498 participants	5 events 75 participants	6 events 330 attendees
Santa Clara	**Year 1**	27,500 Flyers	Not Available	Not Available	8 events 350 participants	41 events 775 attendees
	Year 2	7,000 flyers		Not Available	9 events 10,222 participants	37 events 537 attendees
Ventura	**Year 1**	20,000 Application packages	Not Available	35 events 403 participants	68 events 4,800 participants	350 attendees
	Year 2	Not Available		14 events 134 participants	12 events 217 participants	1 event 6 attendees

Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS

In addition to traditional outreach strategies, some counties have used innovative methods to reach eligible populations, including:

- Contra Costa, Los Angles, and San Francisco counties have developed program websites;
- Los Angeles County queries existing databases to identify potential clients who may be targeted for outreach;
- Orange, Contra Costa and Ventura counties conducted outreach activities targeting homeless individuals, including events at homeless shelters and with providers who serve homeless clients;
- Ventura County has advertised the program in local media including newspaper, radio and television;
- Contra Costa County promotes HCCI to parents when they bring their children to county clinics for care, as well as to community college students who seek primary care or mental health services on campus; and
- Contra Costa, San Diego and San Mateo counties have certified application assistants stationed at sites within the county-wide health care delivery system, such as the Emergency Department at the Regional Medical Center.

Counties have further developed partnerships with other organizations, such as faith-based and other community-based organizations, to provide outreach to the HCCI targeted populations. Los Angeles County worked with other departments in Los Angeles County as well as the local Public Private Partnership Clinics (PPPs) to establish regional/community collaboration. San Francisco County developed a partnership with the city and the county's 3-1-1 system to provide public information on the program. San Francisco County also collaborated with the local Social Services Department.

Expansions in Services

All HCCI counties provide outpatient services and nine out of ten provide emergency and inpatient care to their enrollees under their HCCI program. All HCCI counties have also expanded types of services available in their programs and, in some counties, these expansions have been extensive, providing a broad array of services along the continuum of care. Key service expansions include:

- Inpatient psychiatric and alcohol and substance abuse treatment;
- Outpatient physical, occupational, and speech therapy, audiology, vision, and mental health;
- Skilled nursing care and sub-acute care;
- Home health care;
- Dental care;
- Telemedicine; and
- Smoking cessation.

A comprehensive list of services provided in the first program year is presented in Exhibit 6.

Exhibit 6: Key Service Expansions under First Year of HCCI Program by County

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura	% with Service
Covered Services											
1. Inpatient Hospital											
General acute hospital	X	X	X		X	X	X	X	X	X	90%
Psychiatric hospital	X		X				X		X	X	50%
Inpatient drug and alcohol treatment			X				X				20%
Acute rehabilitation hospital	X	X	X		X	X	X		X		70%
Emergency room	X	X	X		X	X	X	X	X	X	90%
2. Outpatient Hospital Services											
Physician	X	X	X	X	X	X	X	X	X	X	100%
Optometry	X	X	X	X	X	X		X	X		80%
Psychology	X		X				X	X		X	50%
Podiatry	X	X	X	X	X	X	X	X	X	X	100%
Physical therapy	X	X	X	X	X	X	X	X	X	X	100%
Occupational therapy	X	X		X	X	X	X	X	X	X	90%
Speech therapy	X	X		X	X		X	X	X	X	80%
Audiology (includes hearing aids)	X	X	X	X	X	X	X	X	X		90%
Laboratory	X	X	X	X	X	X	X	X	X	X	100%
Radiology	X	X	X	X	X	X	X	X	X	X	100%
Prosthetic and orthotic devices	X	X	X	X	X	X	X	X	X	X	100%
Durable medical equipment	X	X	X	X	X	X	X	X	X	X	100%
Prescribed and OTC drugs	X	X	X	X	X	X	X	X	X	X	100%
Medical supplies	X	X	X	X	X	X	X	X	X	X	100%
Use of hospital facilities	X	X	X	X	X	X	X	X	X	X	100%
Outpatient drug therapy services	X		X	X		X	X	X	X	X	80%
Hemodialysis	X	X	X	X	X		X		X		70%
3. Clinic services: rural health, federally qualified health centers (FQHC), FQHC look-alike, community, county, specialty clinics and state licensed free clinic											
Physician	X	X	X	X	X	X	X	X	X	X	100%
Optometry	X	X	X	X	X			X	X		70%
Psychology	X		X				X	X		X	50%
Podiatry	X	X	X	X	X	X	X	X	X	X	100%
Physical therapy	X	X		X	X			X	X	X	70%
Occupational therapy	X	X		X	X			X	X	X	70%
Speech therapy	X	X		X	X			X	X	X	70%
Audiology (includes hearing aids)	X	X		X	X		X	X	X		70%
Laboratory	X	X	X	X	X	X	X	X	X	X	100%
Radiology	X	X	X	X	X	X		X	X	X	90%
Prosthetic and orthotic devices	X	X		X	X		X	X		X	70%
Durable medical equipment	X	X	X	X	X	X	X	X	X	X	100%
Prescribed and OTC drugs	X	X	X	X	X	X	X	X	X	X	100%
Medical supplies	X	X		X	X			X	X	X	70%
Outpatient drug therapy services	X	X		X				X	X	X	60%
Hemodialysis	X	X			X						30%
4. Laboratory	X	X	X		X	X	X	X	X	X	90%

	Alameda	Contra Costa	Kern	Los Angeles	Orange	San Diego	San Francisco	San Mateo	Santa Clara	Ventura	% with Service
5. Radiology (radiological services, portable imaging, and radioisotope services)	X	X	X		X	X	X	X	X	X	90%
6. Nursing home care: skilled nursing, intermediate care	X		X		X		X				40%
7. Sub-acute care facilities (licensed and certified skilled nursing)	X		X		X		X				40%
8. Physician Services	X		X								0%
Physician services	X	X	X		X	X	X	X	X	X	90%
Dental services provided by a physician	X	X	X		X		X	X	X	X	80%
Telemedicine	X		X				X	X			40%
Smoking cessation	X		X				X	X	X	X	60%
Sign language interpretation	X	X	X				X	X	X	X	70%
9. Dental Services (includes dentures)	X	X	X	X	X	X		X	X	X *	90%
10. Ophthalmology and optometry services, (includes eye glasses and optical fabricating laboratories)	X	X	X		X	X	X	X	X	X	90%
11. Podiatry	X	X	X		X	X	X	X	X	X	90%
12. Home health agency services											0%
Registered nurse	X		X		X		X	X	X		60%
Licensed vocational nurse	X		X		X		X	X			50%
Licensed therapist (physical, occupational, speech)	X				X		X	X	X		60%
Social worker	X		X		X			X	X		50%
Home health aide	X		X					X			30%
Psychology services	X		X					X			30%
Infusion services	X		X		X						30%
Medical supplies, equipment and appliances	X		X		X		X	X			50%
13. Physical therapy	X	X	X		X		X	X	X	X	80%
14. Occupational therapy	X	X	X		X	X	X	X	X	X	90%
15. Speech therapy	X	X	X		X	X	X	X	X	X	90%
16. Prosthetic appliances	X	X	X		X		X	X	X	X	80%
17. Orthotic appliances	X	X	X		X	X	X	X	X		80%
18. Durable medical equipment	X	X	X		X	X	X	X	X	X	90%
19. Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)	X	X	X		X	X	X	X		X	90%
20. Personal care services	X	X									20%
21. Non-emergency medical transportation			X		X	X					30%
22. Acupuncture	X							X	X		30%
23. Blood bank services	X	X	X		X	X	X	X	X	X	90%
24. Outpatient hemodialysis and peritoneal dialysis		X	X		X	X			X		50%
25. Audiology (includes hearing aids)	X	X	X		X	X		X	X		70%
26. Indian health services						X			X		20%
27. Ambulatory surgical center services	X		X	X	X		X	X	X		70%
28. Mental health services	X		X			X	X	X	X	X	70%
29. Medical supplies (includes incontinence supplies)	X	X	X		X	X	X	X	X	X	90%

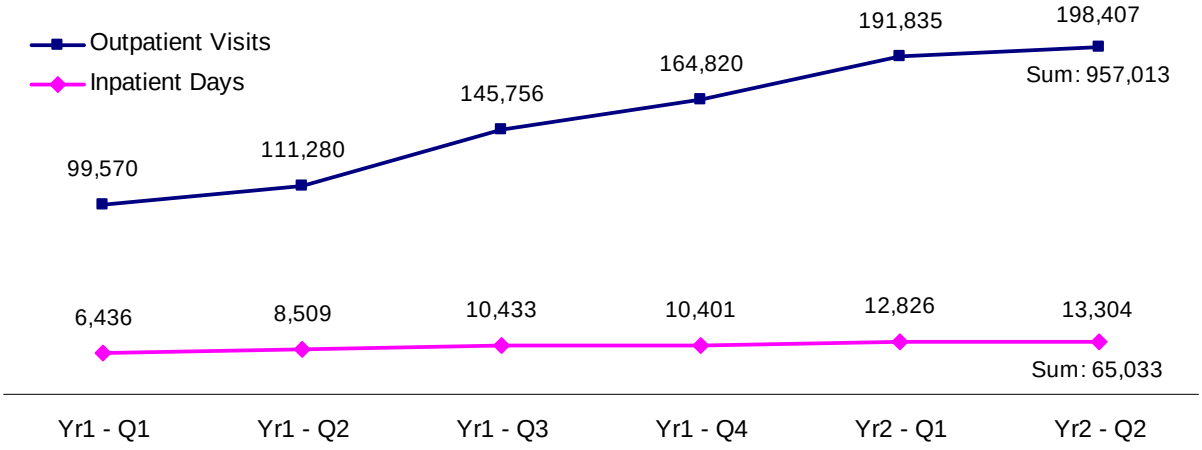
* Ventura County began covering dental services in program year two, through a contract with *Clinicas*.
Source: County contracts with DHCS
Note: At the time of this report, the contract for Los Angeles County had not been executed.

Utilization of Health Services

Inpatient Days and Outpatient Visits

HCCI counties provide data on numbers of inpatient days and outpatient visits in their quarterly progress reports. The number of inpatient days and outpatient visits, unadjusted for enrollment, indicates that the HCCI program has provided a total of 957,013 outpatient visits (including clinic, outpatient hospital and physician visits) and 65,033 inpatient hospital days during the first year and a half of the program. Total outpatient visits increased at a fairly steady rate through the first quarter of year two, but a slight slowing down is seen by the second quarter of year two (Exhibit 7). A steady but slow increase in total hospital days is also observed to date.

Exhibit 7: HCCI Total Number of Outpatient Visits and Inpatient Days by Quarter; Year One and Year Two (Quarters 1 and 2)



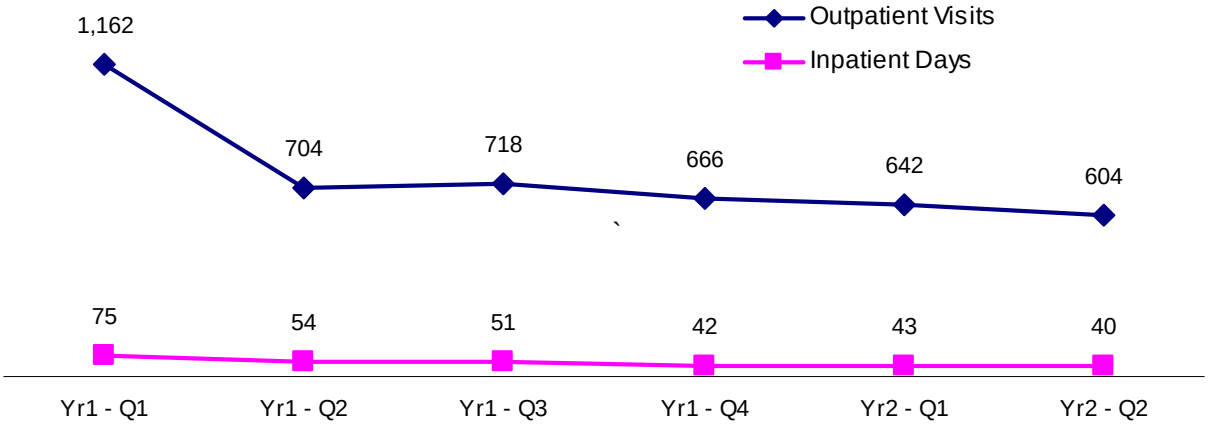
Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS

Utilization rates per 1,000 members per month for the HCCI program as a whole indicate a large initial number of inpatient days and outpatient visits and a declining trend thereafter (Exhibit 8). There are a number of explanations for these trends. First, the method of enrollment in many counties may be one reason for this observed pattern: individuals are often enrolled at point of requesting service. Following the initial visit or inpatient stay, individuals may utilize fewer services over time. However, the initial high rate of service use is likely due to a significant amount of pent-up demand for outpatient services for those newly enrolled. Individuals without prior coverage or access to care may seek care which they had previously delayed. Finally, the observed trends may be due to implementation of the medical home and provision of coordinated care and care management services. Many individuals with chronic conditions who are enrolled in the HCCI programs receive coordinated care and care management services designed to improve patient outcomes. These individuals are likely to have more office visits with providers until their condition is under control and the number of visits is reduced to those for periodic check-ups and to receive preventive care. Delivery of appropriate outpatient care is also likely to reduce the rates of inpatient days, especially for ambulatory care sensitive conditions.

The best method of identifying the level of service utilization is to compare the annual patterns of outpatient and inpatient utilization before and after the HCCI implementation. The data for

such analyses were not available at the time of this report but these analyses are planned for the final evaluation report.

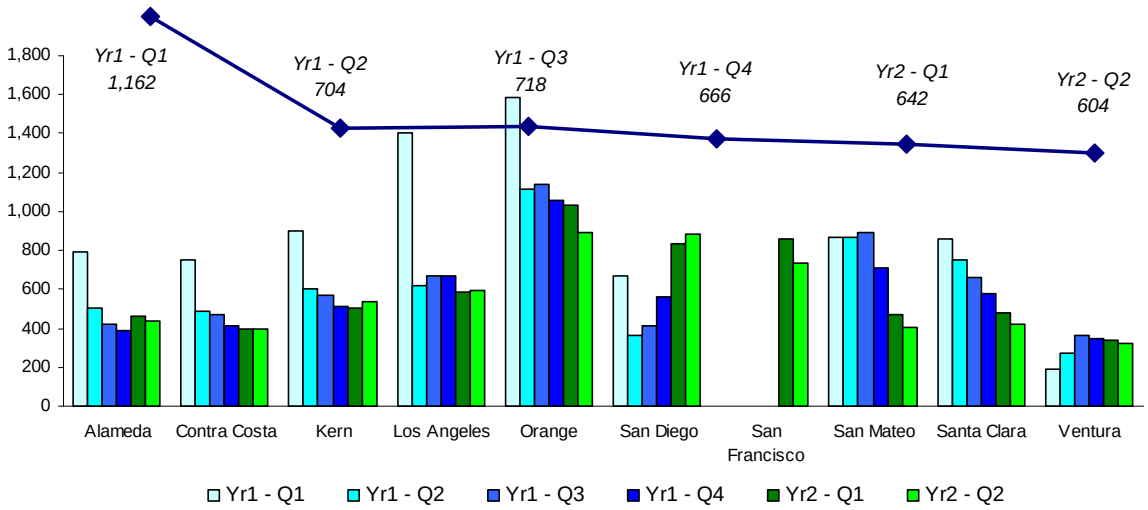
Exhibit 8: HCCI Outpatient Visits and Inpatient Days per 1,000 Members per Month; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS

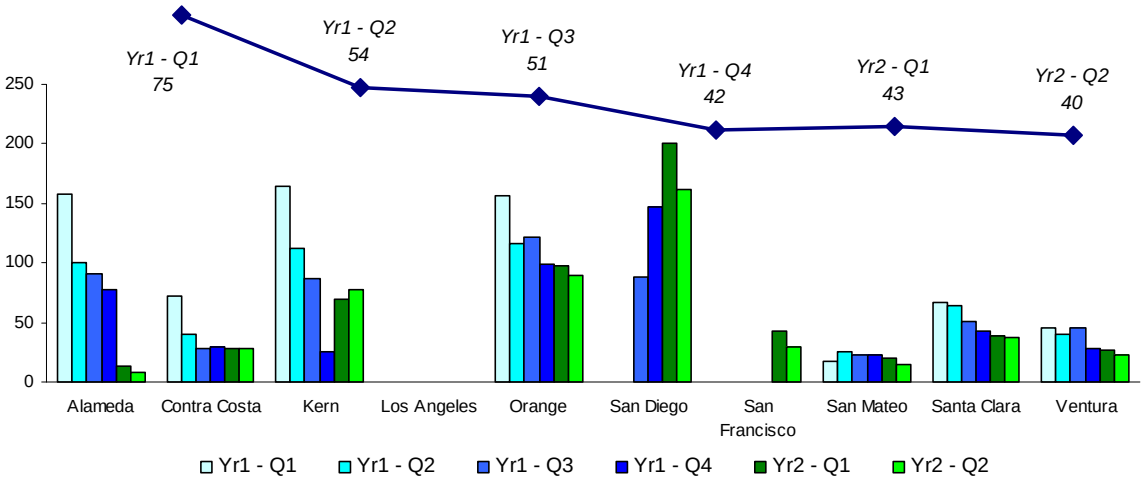
The utilization rates of outpatient visits (Exhibit 9) and inpatient days (Exhibit 10) per 1,000 members per month by county reveal a similar downward trend through the first year and a half of the program for both indicators in most counties with available data. Some exceptions to this pattern exist. San Diego County reports combined outpatient and emergency room visits data, which has likely contributed to a different trend (as indicated in year two, quarter 3 progress report). Also San Diego began rapid enrollment in the third quarter of year one, contributing to the increasing trend in inpatient days due to coverage of services for individuals not previously covered. The reversed trend seen in Ventura County for outpatient visits is likely due to a shift in utilization from emergency department to outpatient visits.

Exhibit 9: Outpatient Visits per 1,000 Members per Month, *HCCI Total* & by County; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS
Note: San Francisco County did not report quarterly data for the first program year

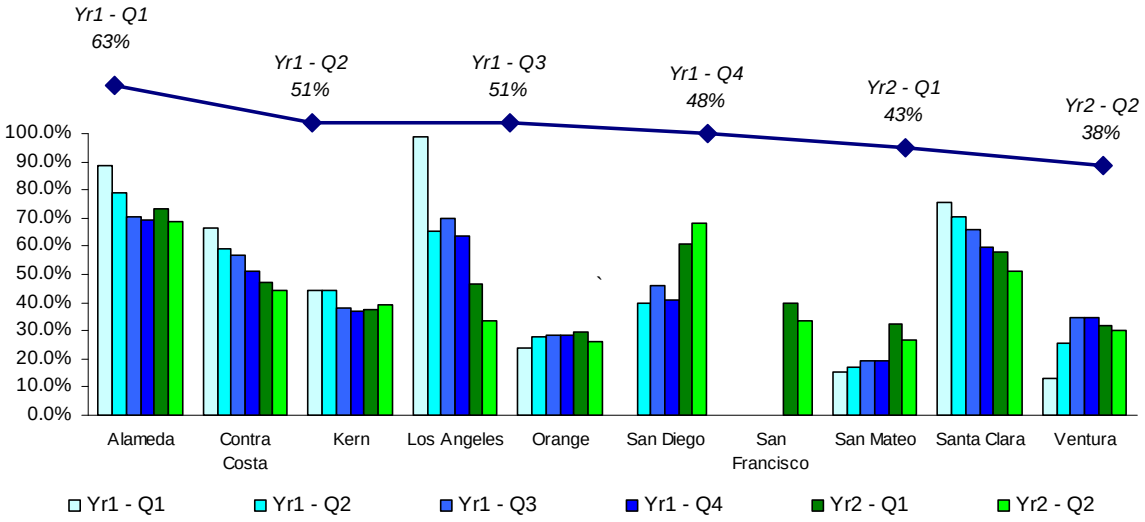
Exhibit 10: Inpatient Days per 1,000 Members per Month, *HCCI Total* & by County; Year One and Year Two (Quarters 1 and 2)



Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS
Note: San Francisco County did not report quarterly data for the first program year

In addition to reporting numbers of outpatient visits in general, counties reported on number of individuals who visited their medical home during each quarter. Of the 96,803 individuals enrolled in the HCCI program during the first year, approximately 69% of these enrollees visited their medical home during the same time period. This discrepency most likely indicates that some individuals did not seek services at their assigned medical homes or that medical home assignment occurred after patients had been enrolled and received care. HCCI counties used differing enrollment and medical home assignment strategies, and some did not enforce adherence to assigned medical home.

Exhibit 11: Proportion of Enrollees Who Visited a Medical Home, *HCCI Total* & by County; Year One and Year Two (Quarters 1 and 2)



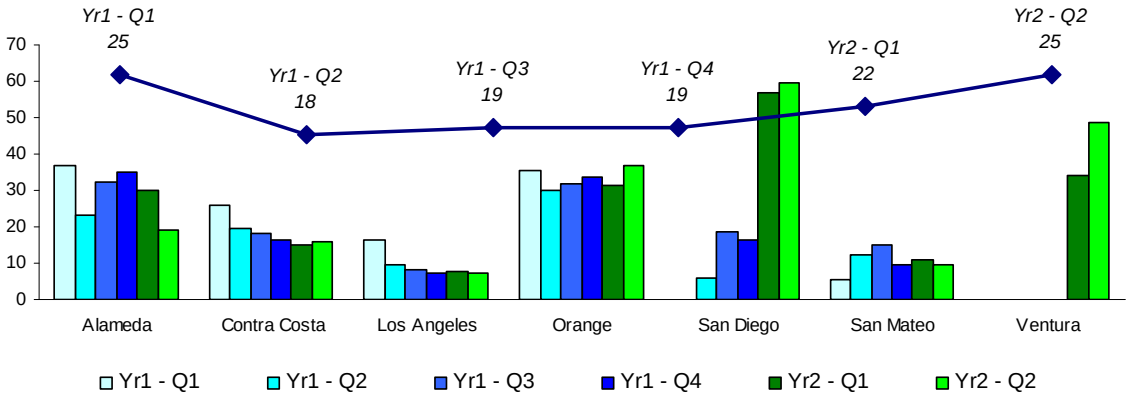
Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS
Note: San Francisco County did not report quarterly data for the first program year

The trend in proportion of enrollees who visited their medical home during each quarter of the program indicates a decline in visits overall. This decline is also observed for several counties (Exhibit 11). In these counties, this trend may reflect an high initial rate of service use due to pent-up demand for care for those newly enrolled and more periodic visits thereafter. However, the reverse trend is observed in some counties and may be attributable to vaired reasons by county. For example, San Diego County reports a visit to any provider in their network as a medical home visit (as indicated in year two, quarter 3 progress report). Ventura County reports a significant shift in utilization from the emergency department to primary care. San Mateo County's increase, particularly in the second program year, may be attributable to restructuring of care delivery in the county. The different trends in Orange and Kern counties may be due to other unknown changes in program implementation. Further program data will help to clarify these trends.

Dental Visits

Nearly all counties include coverage of dental services in their programs. The overall trend in rate per 1,000 members per month indicates an initial surge in dental visits during the first quarter, followed by a relatively flat rate through the end of first program year, and an increase in program year two (Exhibit 12). The pattern in dental services use within the CI as a whole is likely due to pent-up demand for dental care initially, particularly since access to dental services was significantly restricted for the uninsured population prior to the coverage initiative. Those with poor oral health may require multiple visits for restorative care before transitioning to receipt of periodic preventive care. Lack of further decline in dental visits through the rest of the first program year may indicate poor oral health status of the continuously enrolled population. The increase in the rate of visits in the second program year may indicate a change in the enrollee population. Variations in county specific trends may be due to a number of factors. Dental services were not covered in Ventura County in the first year, but were covered in the second program year. San Diego County reported a large increase in dental services in the second year coinciding with a significant enrollment increase in that year. Further program data to clarify the reasons for these trends are required.

Exhibit 12: Dental Visits per 1,000 Members per Month in Counties with a Dental Benefit, *HCCI Total* & by County; Year One and Year Two (Quarters 1 and 2)

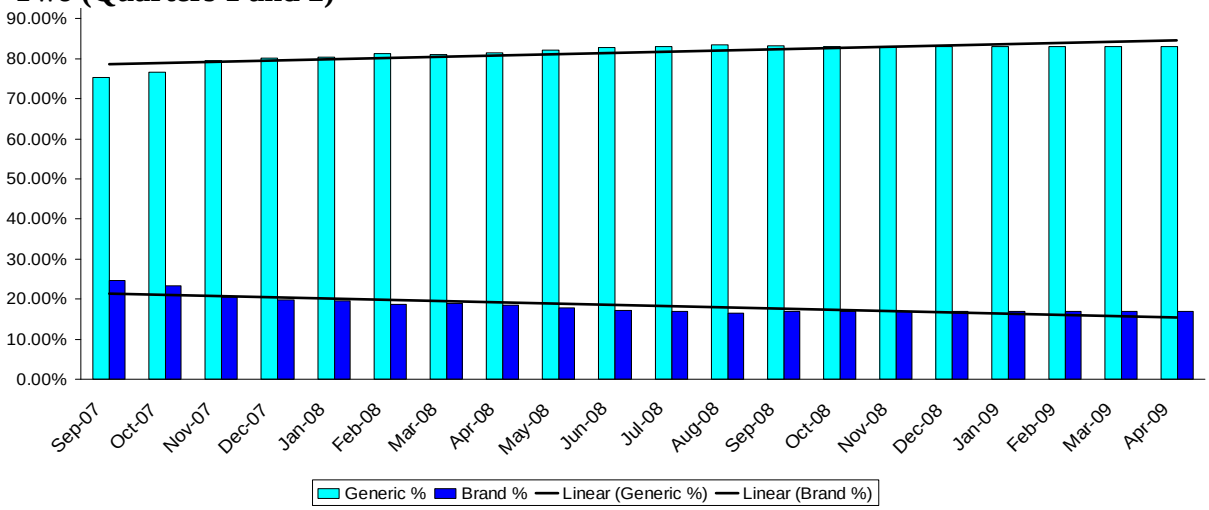


Source: Year one (revised) and year two, quarter 3 county progress reports to DHCS
Note: Ventura County did not cover dental services in the first program year.

Prescription Drug Use

Both Orange and Ventura counties provided basic information on prescription drug utilization. However, extensive information on prescription drug utilization patterns is limited to Orange County (Appendix 14). Their data indicate that nearly 7,600 enrollees were receiving prescription drugs by the end of first program year, with 3.3 prescriptions per user and a total cost of $630,000 or nearly $80 per user. Monthly trends indicate an increase in number of enrollees receiving prescriptions, but a small reduction in number of prescriptions per user leading to a nearly $33 reduction in average monthly cost per member served in the first year. One likely reason for this decline in the monthly per member cost of prescriptions is a 7% decrease in use of brand name prescriptions in the first program year (Exhibit 13).

Exhibit 13: Generic vs. Brand Name Prescriptions, Orange County; Year One and Year Two (Quarters 1 and 2)



Source: Orange County, Appendix 14

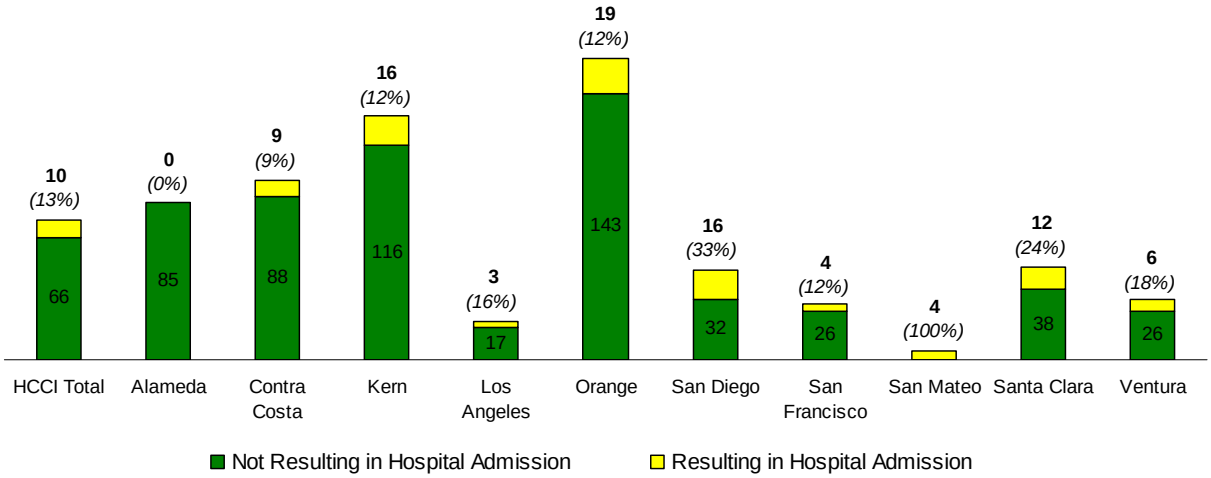
Emergency Room Visits

Emergency room visits are costly and frequently avoidable. Chronically ill patients without a usual source of care often visit the emergency room for conditions that are exacerbated due to lack of access to primary care. Emergency room visits that result in a hospitalization often indicate that the visit was for a life threatening or severe condition. HCCI counties report emergency room utilization on an annual basis. The overall proportion of emergency room visits resulting in hospitalization for the first year of the HCCI program is 13%. The comparable proportion for the entire state of California in 2007 was 16%.[1] This difference may indicate a continuing tendency for HCCI enrollees to use the emergency room for primary care services. This rate varied by county with six counties reporting rates at or below the HCCI program rate of 13% (Exhibit 14). The reported rates of emergency room visits resulting in hospitalizations do not account for differences in illness severity or other characteristics of the enrollee populations in each county. Furthermore, quarterly data were not available to examine whether changes in

[1] (Source: http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/Hospital_Utilization.html 2007, pivot profiles).

emergency visit rates occurred and if they are consistent with trends in inpatient and outpatient service use.

Exhibit 14: Emergency Room Visits Ending in Hospital Admission per 1,000 Members per Month; Year One

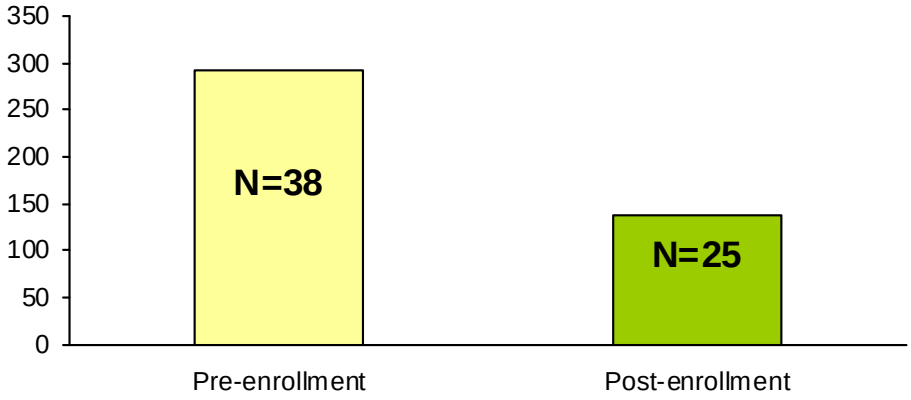


Source: Year one (revised) county progress reports to DHCS

Specific data from Kern County (Appendix 12) provide further insight into whether the HCCI program has influenced emergency room visit rates (Exhibit 15). Among the subset of Kern County enrollees who were identified as high users, had been enrolled for a minimum of 6 months, and received case and disease management services, annual emergency room visits decreased by more than half. The data were based on 292 visits in the pre-enrollment period generated by 38 patients. After enrollment and with case management, only 25 of these patients visited the emergency room, generating 88 visits.

The definitive impact of the program on emergency room visits will be examined at the end of the program and reported in the final evaluation report.

Exhibit 15: Annual Emergency Room Visits for Actively Care Managed Patients, 6 Months Minimum Enrollment



Source: Kern County, Appendix 12

Quality of Care

Quality of care is assessed at three levels: structure, process, and outcomes. Structure measures include availability of infrastructure such as data systems, guidelines, personnel, and services required for delivery of high quality of care. Process measures refer to receipt of care in concordance with guidelines including receipt of condition, gender and/or age specific services. Outcome measures refer to various measures of impact on patients of the delivery of high quality care. Outcomes can be measured as the changes in clinical status of the patient (such as lower blood glucose level), changes in patients' quality of life, or changes in perception of and satisfaction with the care received.

Structure Measures

The analysis of structure measures in the first year of the HCCI program in this report focuses on availability of data systems, databases, and guidelines developed or used by participating counties. Exhibit 16 presents the efforts of HCCI participating counties to implement this aspect of quality, including dissemination of quality of care guidelines, the use of HEDIS measures and the sources of data for measurement of quality of care and health outcomes by county.

Exhibit 16: Structure Measures of Quality of Care by County; Year One

	Dissemination of Evidence Based Guidelines	Use of HEDIS Measures	Claims or Admin Data	Chart Reviews	Disease Registry / Clinical Record	Electronic Medical Record	Pharmacy Data	Lab Results	Patient Satisfaction
Alameda	X	X	X	X	Diabetes	Other	X	Unknown	X
Contra Costa	X	X	X	X	Diabetes Asthma Other	Other	X	Unknown	X
Kern	X	X	X	X	Diabetes	X and Other	Unknown	Unknown	X
Los Angeles	X	X	X	X	Diabetes CHF Asthma	Other	X	Unknown	Patient complaint system only
Orange	X	X	X	No	Diabetes CHF Hypertension Asthma	X	X	X	X

	Dissemination of Evidence Based Guidelines	Use of HEDIS Measures	Claims or Admin Data	Chart Reviews	Disease Registry / Clinical Record	Electronic Medical Record	Pharmacy Data	Lab Results	Patient Satisfaction
San Diego	X	X	X	X	Diabetes Hypertension Hyperlipidemia	Other	Unknown	X	X
San Francisco	X	X	X	No	Diabetes	X and Other	X	X	X
San Mateo	X	X	X	X	Diabetes Hypertension Other	X and Other	Unknown	Unknown	X
Santa Clara	X	No	X	No	Diabetes	X and Other	X	X	X
Ventura	X	Planned	X	Partial	Diabetes	Other	X	Unknown	X

Source: Key informant interviews, county contracts with state, *Health Coverage in the Safety Net:: How California's Coverage Initiative Is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings* (Appendix 1) and County Medical Home Implementation Narratives (Appendices 2-11)

System-wide adherence to guidelines for chronic conditions is valuable in ensuring consistent improvements in patient care. Appropriate management of conditions such as diabetes includes control of blood sugar level to prevent the development of related complications including but not limited to cardiovascular disease, renal disease, peripheral vascular disease and neuropathy (nerve damage leading to numbness). These complications may lead to non-traumatic amputation, retinal disease and blindness, and cerebrovascular disease. The current recommendations for management of diabetes include optimal level of blood sugar (Hemoglobin A1c) at 7 or lower; maintenance of the low-density lipoprotein (LDL) level below 100; blood pressure control with a systolic blood pressure below 130mmhg; annual dilated retinal exam; annual microfilament exam (to detect numbness in extremities); and annual screening for proteinuria (protein in the urine as an indicator of renal disease). In addition, individuals with diabetes should receive usual preventive health care including annual flu shots and a pneumonia vaccination every five years.

Appropriate care for asthma and chronic obstructive pulmonary disease (COPD) include receipt of influenza and pneumonia vaccinations to reduce the risk of serious infection, the development of an action plan with one's provider based on symptoms, and pharmaceutical treatment where indicated either for daily control of symptoms and/or control of symptom flares. Control of congestive heart failure (CHF) occurs via optimization of cardiac functioning and the avoidance

of preventable complications, including blood pressure control, daily monitoring of weight, adherence to a low-sodium diet, the use of appropriate medications and LDL control, as well as use of emergency room services and hospitalization when indicated.

Hypertension control requires blood pressure control and reduction in associated complications including cardiac risk factors. Blood pressure monitoring, use of appropriate pharmaceuticals, and cholesterol monitoring and control are key. Dietary and weight loss interventions are also important to achieving these goals. The basis of dyslipidemia (abnormal amounts of lipids in the blood, such as elevation of total cholesterol) quality of care is the reduction of cardiac risk, primarily in people with specific risk factors (e.g., diabetes or hypertension), but also for prevention in individuals with other risk factors such as obesity and tobacco use. Monitoring of dyslipidemia is performed via fasting lipid panels with a specific focus on LDL and triglyceride levels and treatment.

HCCI participating counties have developed guidelines and specific goals for their providers. Exhibit 17 provides an example of some of the guidelines developed by San Mateo County (Appendix 13).

Exhibit 17: Chronic Disease Management Clinical Guidelines and Goals, San Mateo County

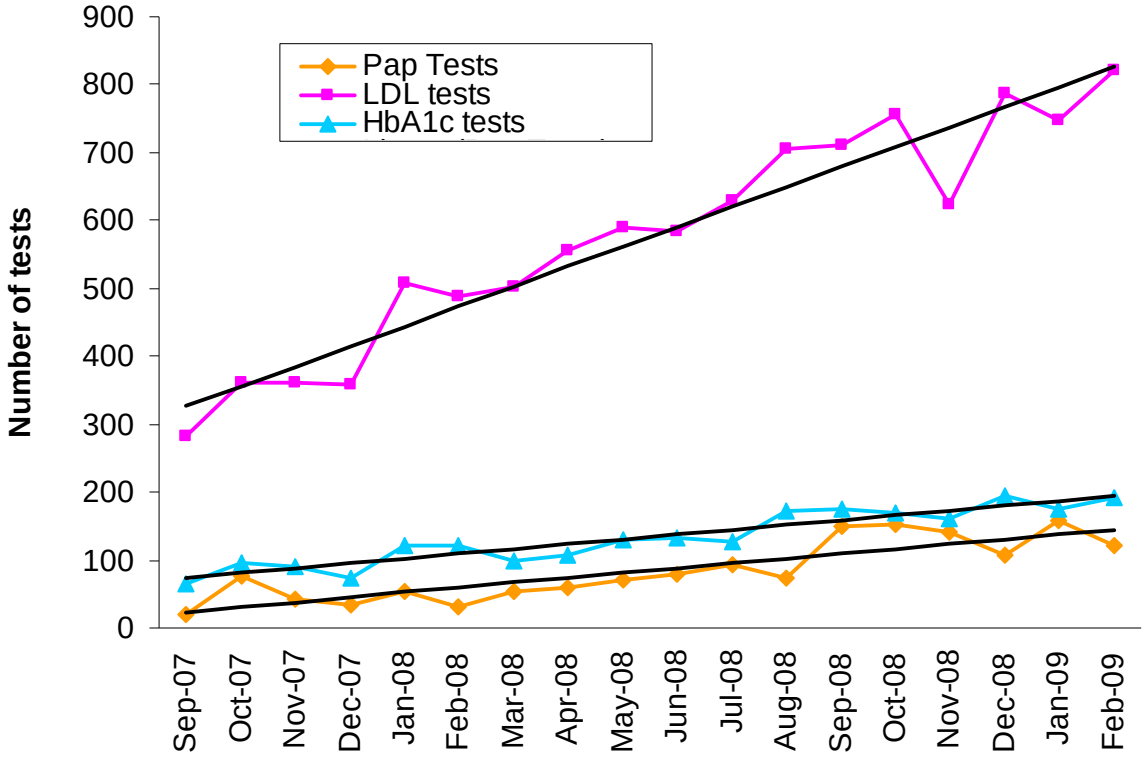
Chronic Disease Management	
HbA1c (%<7.0)	60%
LDL (%<100)	70%
Pneumovax	**80%**
Flu Vaccine	80%
Eye Exams	**80%**
Foot Exams	**80%**
Self Management Goals	**80%**
ASA	**80%**
BP (%<130/80)	60%

Source: San Mateo County, Appendix 13

Process Measures

Availability of guidelines and setting specific goals are the first steps in delivery of high quality care. The next step is to ensure that services are delivered according to guidelines. Available evidence from Orange County (Appendix 14) indicates that delivery of primary and preventive care services including cervical cancer screening (Pap tests), cholesterol tests, and blood glucose tests have increased in the first year of the program (Exhibit 18).

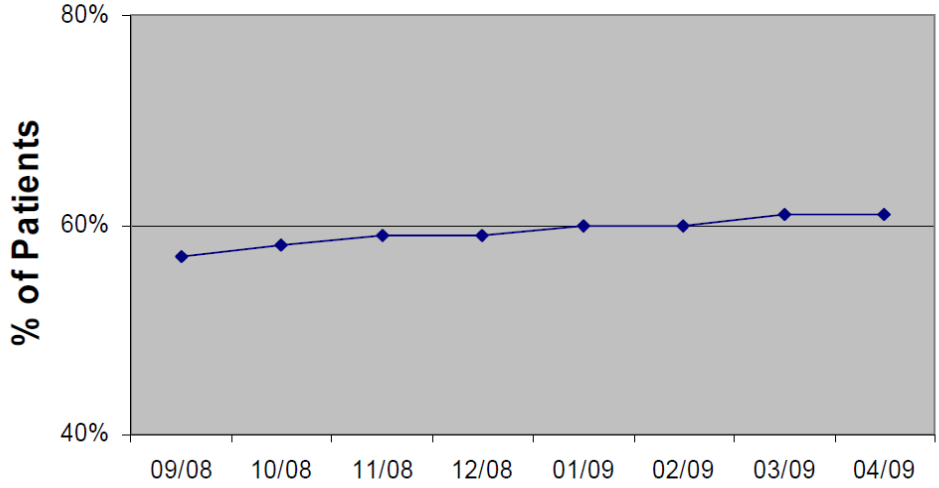
Exhibit 18: Number of Pap, Cholesterol and Glucose Tests, Orange County



Source: Orange County, Appendix 14

Data on vaccination rates for the first year of the program are not available. However, data for the second year of the program from San Mateo County's diabetes registry (Appendix 13) shows a gradually increasing rate of pneumonia vaccinations among the 1,400 patients enrolled in the diabetes registry through the County's HCCI program (Exhibit 19).

Exhibit 19: Monthly Pneumonia Vaccination Rates, San Mateo County

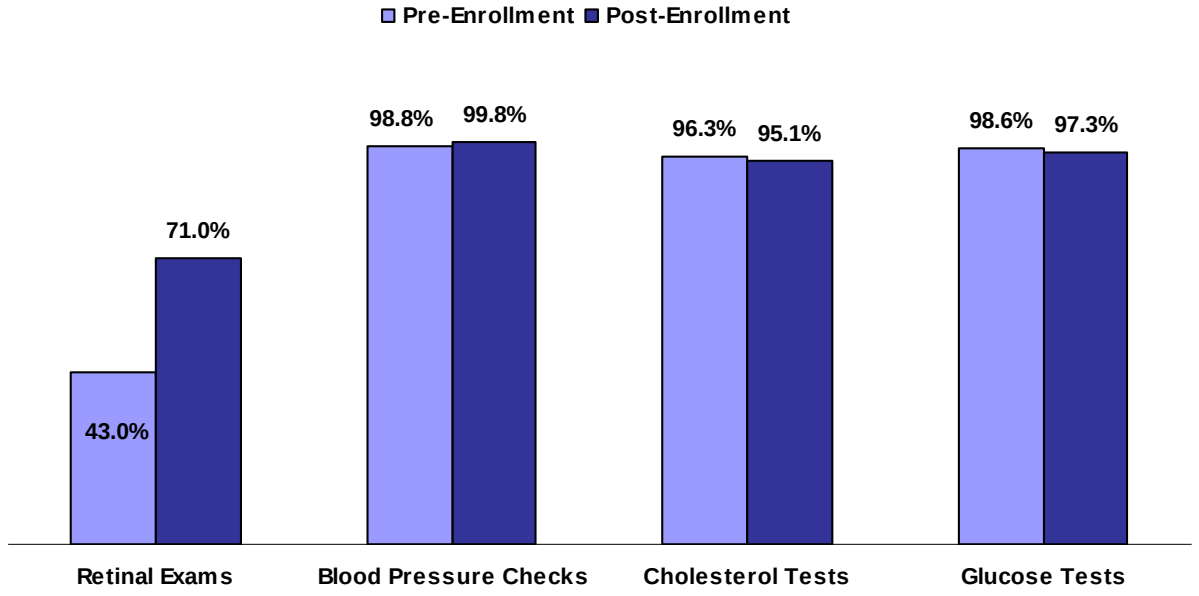


Source: San Mateo County, Appendix 13

Data from San Diego County from February 1, 2008 to April 30, 2009 (Appendix 15) reveal a significant growth in the percentage of patients with diabetes who received retinal exams (Exhibit 20). There are data from 484 patients in the pre-HCCI period and 408 in the post-HCCI period. The retinal screenings were conducted under a specific research project that sent a mobile retinal screener to Project Dulce clinics over an 18 month period (Appendix 15). This effort largely accounts for the success in improving retinal exam rates seen in Exhibit 20, and may be a cost effective and replicable strategy for the rest of the providers in San Diego County.

The high screening rates for blood pressure, cholesterol and glucose tests appear to remain similar pre and post HCCI enrollment. The HCCI program in San Diego County is limited to diabetes care management and it is likely these individuals received these screening services from a variety of providers in different settings including emergency departments prior to HCCI implementation. However, appropriate care management resulting in improved patient outcomes is unlikely with episodic care delivered in emergency rooms. More information on patient outcomes in San Diego County is provided in the next section and indicates improvements in all three measures.

Exhibit 20: Percentage of Exams/Tests Pre and Post HCCI Enrollment, San Diego County



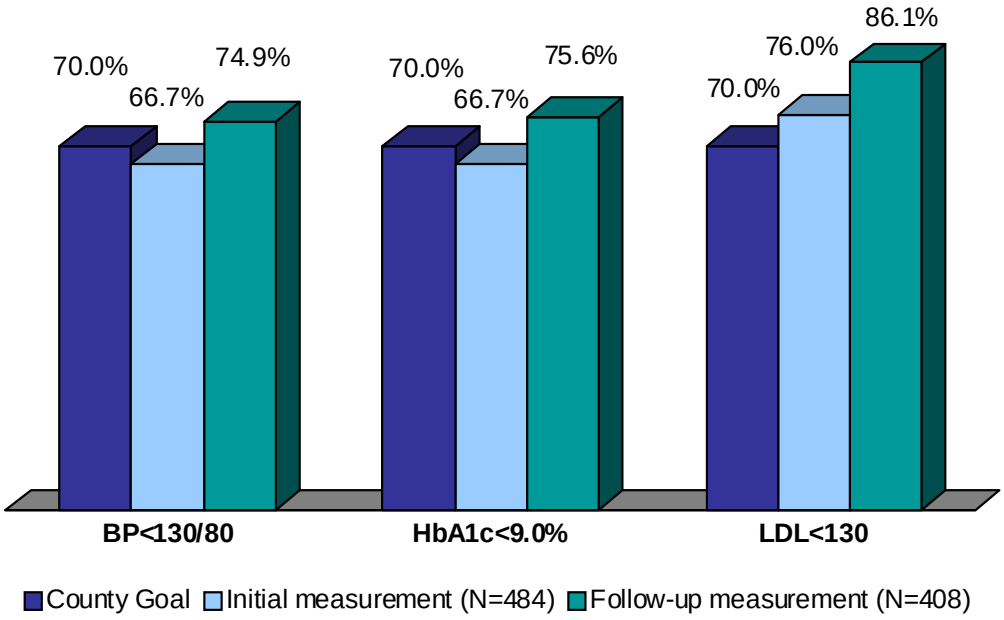
Source: San Diego County, Appendix 15

Outcome Measures

Changes in specific clinical measures indicate whether the guideline concordant management of patients has had a perceptible impact on their clinical status. Multiple measurements of clinical outcomes over time are required to assess such changes, particularly since patient compliance with provider recommendations requires frequent reinforcement during visits and other interactions with the multidisciplinary staff.

Exhibit 21 provides data on three clinical outcomes from San Diego County (Appendix 15). The data indicate that the proportion of the enrollee population with blood pressure, glucose, and cholesterol levels within guideline concordant levels has increased between the initial measurements at time of enrollment and measurements after receipt of disease management services. In all cases the proportions exceed the county goal.

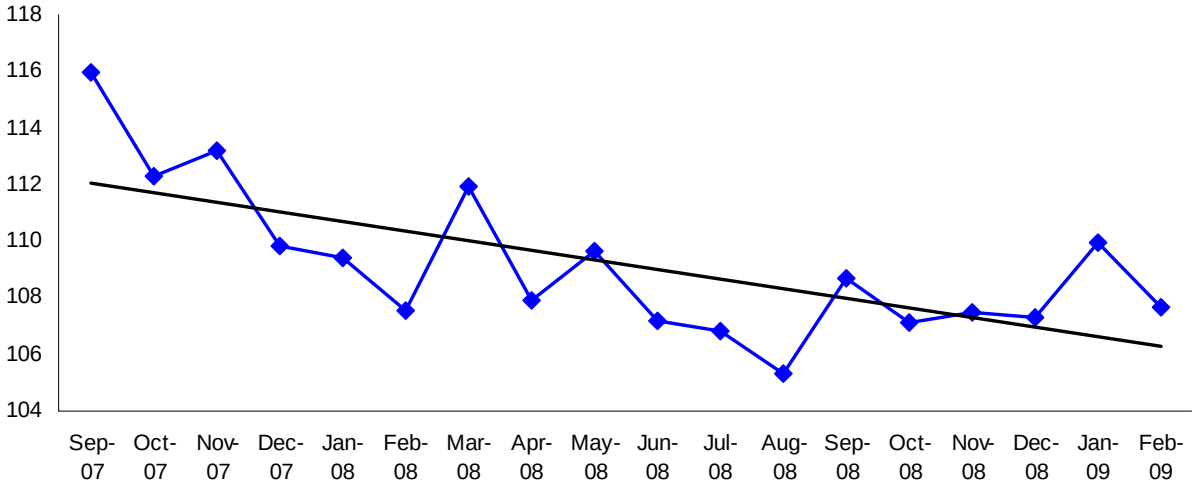
Exhibit 21: Diabetes and Hypertension Clinical Outcomes, San Diego County



Source: San Diego County, Appendix 15

Data from Orange County (Appendix 14) for the first program year indicate that cholesterol levels have declined since the beginning of the HCCI program (Exhibit 22). These data do not account for chronic conditions of the enrolled population.

Exhibit 22: Cholesterol (LDL) Levels in Orange County



Source: Orange County, Appendix 14

Quality-of-life and patient satisfaction measures provide a different perspective on the impact of delivery of care on patients. Improvements in clinical outcomes should coincide with improvements in patients' perceptions of their health as well as positive experiences during receipt of services. Data to assess these specific outcomes of care were not available at the time of this report.

System Design and Innovation

The stated goals of the initiative that created the HCCI program require a significant level of system redesign and innovation. Of the seven goals, strengthening and building upon the local health care safety net system, improving access to high quality health care, creating efficiencies in the delivery of health services, and providing grounds for long-term sustainability of the programs are heavily dependent on shifting the paradigm of health care delivery within the safety net. Within the first program year, HCCI counties have pursued a number of innovative strategies to create systems of care and redesign health care delivery. Four such major innovations and redesign efforts are discussed in this report and include implementation of the medical home model; redesign of delivery of specialty care; creation of provider networks; and innovations in enrollment and outreach.

Medical Home Implementation

The concept of the medical home was first introduced in 1967 and has been further enhanced and revised in subsequent years. The concept was most recently renamed and refined in 2007 as the "Patient-Centered Medical Home (PCMH)." Parallel to the development of the medical home model, the "chronic care model (CCM)" was first proposed as an effective means of providing primary care to patients with chronic illness. The latest iteration of CCM developed in 2006 was called "advanced medical home (AMH)," and further aligned the CCM and PCMH concepts. These concepts call for a redesign of delivery of care to all patients and are intended to address the shortcomings of the current system of care. Under the current system of care, many patients, including privately and publicly insured individuals as well as the uninsured, lack a usual source of care that ensures continuity of care. As a result, they visit multiple providers treating different problems without simultaneously considering overall health; receive duplicative and uncoordinated services; receive care that is not concordant with guidelines and may not be of high quality; have limited access to primary care providers potentially leading to unnecessary use of other services such as emergency rooms; and lack supportive services that improve their participation in self-management of chronic conditions. An effective medical home redesign must address these problems and provide the financial incentives to providers to deliver the additional services that would be required as the personal physician responsible for all the patient's health care needs, who takes on the leadership for a team of providers to deliver integrated and coordinated care.

The implementation of the medical home concept is an ideal that is as of yet unattained for the majority of the population of the United States. Existing models are frequently pilot projects that have implemented some aspects of the medical home concept in limited populations within pre-existing systems. The information on success of these programs in improving patient outcomes is gradually forthcoming but currently limited and not clearly duplicable in other settings. These

factors highlight the innovative nature of the implementation of the medical home concept within the safety-net system and the HCCI program.

To date, HCCI participating counties have implemented multiple aspects of the medical home concept, taking different approaches. Some counties have focused more closely on chronically ill populations with greater emphasis on quality of care, while others have focused on integration of a larger population of enrollees with greater emphasis on enhanced access. A thorough analysis of the implementation of the medical home concept in the HCCI program and recommendations for further enhancements is provided in Appendix 1 in the publication titled: *Health Coverage in the Safety Net: How California's Coverage Initiative Is Providing A Medical Home to Low-Income Uninsured Adults in Ten Counties, Interim Findings*. Appendices 2-11 include further detail on implementation methods for each participating county.

Specialty Care Redesign

One of the most challenging aspects of health care delivery to uninsured low-income populations using the safety-net system has been provision of specialty care. In most cases, specialty care access is severely limited by the small number of specialists available to uninsured patients. Long wait times of several months for appointments are not uncommon. Systemic inefficiencies are common, including lack of electronic referral and tracking systems; unavailability of medical records accurately documenting patient history and previously provided services; and lack of guidelines for delivery of care to chronically ill populations within the primary care environment to reduce the need for specialty referrals. Lack of systematic oversight of providers operating under different systems or no systems, and reimbursement mechanisms that do not provide the needed incentives for management of chronic conditions contribute to challenges in specialty care delivery under the safety-net system.

Specialty care redesign is closely linked with the implementation of the medical home concept, since multiple aspects of an ideal medical home address the challenges of delivery of specialty care. In particular, advances in the implementation of medical home in HCCI counties have provided a number of tools to improve delivery of specialty care. For example, use of clinical decision-support tools can provide guideline concordant instant advice to primary care providers, reducing the need to refer some patients, or increasing ability to perform necessary tests or minor procedures prior to patient referral. Three counties (San Mateo, Santa Clara, and San Francisco) currently utilize decision-support software broadly with limited use of such software in two other counties (Los Angeles and Ventura). While availability of such tools among participating HCCI counties is not widespread as of yet, the impact on patient care among counties with these tools is likely to be significant.

Electronic medical records (EMRs) or other less comprehensive electronic information systems that are available system-wide are perhaps the most important element in creating communication channels between specialty and primary care providers, reducing the need for patient referrals, and streamlining efficient use of specialty care. Specialist access to electronic records and incentives to provide feedback to primary care providers have the potential to dramatically enhance the effectiveness of these tools. While the availability of fully implemented EMRs among HCCI participating counties is currently limited, at least three counties (San

Francisco, San Mateo, and Santa Clara) utilize lifetime clinical records that combine all available administrative, encounter, referrals, registry, and prescribing data for providers. Counties without these systems utilize other tools such as registries, summary sheets, or other less comprehensive electronic care records to improve continuity and data availability. Advances towards creation of an ambulatory EMR have been made in San Mateo County. Orange County has specific systems for emergency room and community clinics with capacity for identifying utilization data, provider's notes, and referrals. Some counties have incorporated electronic specialty referral capacity in their systems. The impact of these resources on specialty care and referrals is yet to be assessed.

At least two HCCI participating counties have conducted more intensive efforts in redesigning delivery of specialty care. These efforts have focused on expanding the scope of practice of primary care providers to improve management of specific conditions in the primary care setting. Innovations in primary care provider training and support may be able to reduce unnecessary specialty care referrals and create efficiencies in delivery of care.

Alameda County provided one week, hands-on training in clinical management of diabetes in specialty clinics. Primary care providers learned to conduct further diagnostic work-up and minor procedures in the primary care setting before referring patients to specialists. Within their own clinics, these physicians can advise other physicians in management of such conditions. Furthermore, trainings provided opportunities for more direct professional interaction between primary care providers and specialists in the form of phone consultations where specialists could recommend the best course of action in management of complicated problems in the primary care setting without requiring a specialty referral. Alameda has also implemented telemedicine with UC Berkeley's optometric clinic, improving access to optometry services.

Kern County implemented a "mini-fellowship" program in spring 2009. Under this program, selected HCCI primary care providers undergo training with a Kern Medical Center (KMC) specialist to gain the clinical expertise necessary to implement and follow the *consensus care guidelines*. Training begins with a pre-test for primary care providers, a lecture from the specialist, a review of relevant literature, and then a visit to the specialty clinic. At the conclusion of the training, there is a post-test. Upon completion of the fellowship, some primary care providers are certified as *Specialty Champions*, and are reimbursed for phone consultations and chart reviews to evaluate patients with a specialist. Furthermore, *Specialty Champions* within community clinics have responsibility to assure proper use of and compliance with *consensus care guidelines* within their practice site, and are compensated at an enhanced rate if they provide a champion visit for another provider in their group. In Kern County in particular, this approach is effective, as the dispersal of the population and the centralization of specialty care within the county necessitate significant travel for many specialty appointments.

Other significant efforts in redesigning delivery of specialty care include in-depth oversight of primary care practice patterns regarding specialty referrals. Such efforts are often employed by managed care organizations or other systems of care delivery through utilization review and management. However, precedence for oversight of referral patterns at the county level and within the safety-net system is scarce. Anecdotal evidence suggests that the ability to impact practice patterns of all safety net providers in the system has led to reductions of unnecessary

referrals and further physician training to provide better and more appropriate care. Further investigation of these effects is required.

Further efforts to improve access to specialty services include additional contracting with community providers in several counties, aimed at increasing the supply of specialists. Collectively, these efforts are anticipated to significantly reduce number of referrals and waiting times for specialty care.

Innovations in Creating Provider Networks

In the U.S., health care primarily is delivered by a combination of individual providers, provider groups, clinics, and hospitals that may or not belong to various and often multiple networks. Frequently, safety-net providers do not belong to a single provider network organized and managed by the county in which they operate and receive reimbursement for their services. However, ad hoc provider networks made up of county health department clinics and public hospitals, Federally Qualified Health Centers, and other private community clinics frequently operate within the safety-net.

The safety-net system has been criticized for lack of continuity of care between primary, specialty, emergency, and inpatient services.[2] Despite provision of high quality primary care by providers such as community clinics significant barriers to additional services persist.[3] Shortages of specialty providers who accept Medicaid payment rates have led to provision of these services by county hospitals and emergency departments.[4] Similarly, lack of access to diagnostic referrals, lab services, mental health care, dental services, and pharmaceuticals are prevalent in local health care safety-net systems.[5]

A organized provider network has the potential to strengthen and build upon the local safety-net system and create further efficiencies in delivery of care. Creation of a provider network under HCCI has been challenging but remains a major accomplishment of the program. The program can be credited with innovations in provider network design including public-private partnerships, expansions of traditional safety net providers, improved collaborative activities among disparate providers, and improvements in continuity of care and care coordination among others.

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[2] Cook NL, Hicks LS, O'Malley AJ, et al. Access to Specialty Care and Medical Services in Community Health Centers. *Health Affairs*. 26(5): 1459-68, 2007.
[3] Politzer RM, Yoon J, Shi L, Hughes RG, Regan J, Gaston MH. Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care. *Medical Care Research and Review*, 58(2): 234-248, 2001.
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[5] Regenstein M, Nolan L, Wilson M, Mead H, Siegel B. *Walking a Tightrope: the State of the Safety Net in Ten U.S. Communities.* Washington, DC: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, May 2004. Accessed on August 11, 2009 at http://urgentmatters.org/318852/reports.

The HCCI program has allowed several counties to deviate from the limited safety net "model." Orange and San Diego counties did not have a county (i.e. public) hospital that acted as the safety-net facility of last resort. The care of uninsured patients was dispersed among the private hospitals in these counties who provided episodic and expensive uncompensated care to the indigent population. Patient care was not coordinated due to lack of incentive for private hospitals. Safety-net clinics provided primary care and received county subsidies in return. However, specialty referrals and coordination between different providers was limited in scope and lacked continuity.

Under the HCCI program, Orange County has leveraged HCCI funds to create a comprehensive network of providers including primary care providers within safety net clinics, primary care providers in private practice, specialists in private practice, specialists in private hospitals, pharmacies, emergency rooms, private hospitals, and other essential service providers. Extensive coordination is thus fostered within the network. By reimbursing providers at enhanced rates for specialists and generous global fees, comparable to the FQHC payment rate for primary care, Orange County has encouraged participation between providers and improved care coordination. Specific Health Information Technology (HIT) services, highly effective involvement of the medical director and other staff to integrate case management, utilization review, and provider coaching have allowed the HCCI provider network to function more like a managed care organization.

Contra Costa County HCCI program is delivered through the Contra Costa Health Plan. The County has expanded services through a previously existing program called "Basic Health Care." The network and service delivery are modeled similar to the Contra Costa Health Plan with increased access to dental, specialty, pharmacy, diagnostic, and inpatient services, which were not available through the previous program. The managed care approach in Contra Cost County represents a significant improvement in delivery of care to low-income uninsured populations previously unavailable.

In contrast to counties with existing systems of care to build upon, Ventura County created a provider network and expanded services under the HCCI program. The Ventura County HCCI program or ACE is centered on the Ventura County Medical Center. However, the County contracts with local FQHCs, medical groups, and private physicians to enhance access to primary and specialty care and to improve access to enrollees in more distant areas. Ventura County has formed alliances between Ventura County Medical Center, Turning Point Social Workers, Clinicas del Camino Real, and private physician groups for ophthalmology and other specialty services. The wider network of providers in the county allows for effective care coordination by case managers. Ventura County is one of the few counties that provide behavioral health services. The County has developed a pharmacy formulary to better mange provision of medications, and provides discharge planning, dietician support, and chronic care management among other services.

Public-private partnerships have been established in multiple counties. Private clinics in Los Angeles County were safety-net providers prior to HCCI, but these relationships are significantly reinforced under the program. Contra Costa, Santa Clara and Orange counties have enrolled private safety net providers, such as community-based private practice physicians, community

clinics, and hospitals, to develop a managed care style network that encompasses both public and private providers. In Orange and San Diego counties that lack public hospitals, HCCI has allowed the local government indigent care programs to contract and better coordinate with private facilities that usually provide episodic care to uninsured patients.

HCCI has also allowed participating counties to develop better coordinated monitoring of care provided to their enrollees. Kern County has implemented regular meetings with the medical directors of medical home clinics to review guidelines and utilization data, and to change practice patterns. These meetings have worked to reduce barriers to effective communication within the county and present a viable model for improving quality of care through formation of "physician quality advisory committees."

Innovations in Enrollment and Outreach

The methods of outreach by HCCI counties are displayed in Exhibit 5. A number of these techniques represent innovative approaches that allowed each county to successfully enroll eligible populations that are not captured with more traditional approaches. These innovations include: multilingual program announcements; presentations to labor groups, churches, temples, chambers of commerce, faith-based organizations, and community-based organizations; participation in community events; neighborhood canvassing; employment of outreach staff representatives (Promoters) from the county's diverse communities; enrollment announcements at clinics within the provider network; and direct contacts with small businesses, homeless individuals, and college students.

Several counties succeeded in recruiting from hard-to-reach populations, such as homeless individuals and students and worked through other existing health care programs to recruit enrollees.

- Contra Costa County program staff who oversee services to the homeless, in a program called "Homeless Outreach Projects to Encampments (HOPE)", were trained to assist homeless individuals in enrolling in HCCI.
- Ventura County hired public health nurses, who are well connected with the community, to conduct outreach at a local tent community where homeless individuals reside. They also created a weekly "one-stop shop" for the homeless where the homeless individuals can receive a number of services including health care.
- Orange County's outreach included events with providers that provided care to homeless patients and at homeless shelters.
- Contra Costa screened students at five Contra Costa Community Colleges who sought primary care or mental health services on campus for HCCI eligibility.
- Ventura County held enrollment events at local junior colleges and the California State University, Channel Islands.
- Contra Costa County screened parents of children enrolled in Medi-Cal or Healthy Families and provided assistance with completing enrollment forms for eligible individuals. Special attention was placed on promoting HCCI to parents when they brought their children to County Health Centers for appointments or care. First-time mothers and individuals with HIV/AIDS and tuberculosis were also targeted.

- Ventura County included HCCI related information for the uninsured who are seeking medical care in the "2-1-1 Ventura County" program. The program is operated by Interface Children Family Services and provides 24-hour County-wide comprehensive information and referral services for assisting the community in finding available resources.
- San Francisco County developed a partnership with the City and with the County's 3-1-1 system to provide public information about the program, and collaborated with the Human Services Agency to also provide information about the program on their website.
- San Diego County provided information on the HCCI program on San Diego 2-1-1, including eligibility criteria and contact information.

Other Examples of Innovation in System Redesign

Pilot Medical Home Model: Innovative Care Clinic (ICC) of San Mateo County

San Mateo County's HCCI program (ACE) has established the ICC as a pilot initiative. ICC aims to redesign the care delivery system by developing a team-based approach and focusing on preventive care and early intervention. ICC is the largest adult clinic in the program and is designed to encompass multiple elements of the medical home. ICC provides patient-centered care, improved access, high quality evidence-based medicine, improved management of chronic conditions, and care coordination. Each patient at the clinic is assigned to a provider team that delivers care, handles scheduling, and provides advice by telephone. Team members are encouraged to promote flexibility in the definition of their team roles.

ICC has also undertaken a diabetes disease management program. At each visit for a patient with diabetes, staff collect clinical measures and enter them into the diabetes registry, and provide patient education. Diabetes disease management is promoted in the clinic waiting room with flyers including information about diabetes and invitations to attend diabetes group classes. ICC is transitioning to "Advanced Access" scheduling in 2009 to decrease wait times for appointments. Under Advanced Access, a portion of each team's appointment time is kept open for unscheduled patients to avoid turning patients away. Advanced Access is designed to facilitate consistent care with the same provider by keeping provider schedules mostly open at the beginning of the day. The model of care delivery in ICC is gradually being implemented in the rest of the San Mateo system of care.

Chronic Care Model: Panel Patient Management

Alameda County implements the chronic care model in delivery of care to HCCI patients. The county has incorporated panel management, an innovative approach to systematic delivery of primary care to groups of patients with specific chronic illnesses or at high risk. Panel management is conducted by dedicated support staff that maintain and use a registry to identify populations of patients at risk or with specific chronic conditions and assess their level of need and gaps in services required for their clinical management. Panel managers interact with patients to enforce compliance with care protocols including regular visits for prescription refills and follow-up calls to patients with poor clinical outcomes. Panel managers provide such patient

information to primary care teams including physician team leaders and thus assist in improved management of these patients.

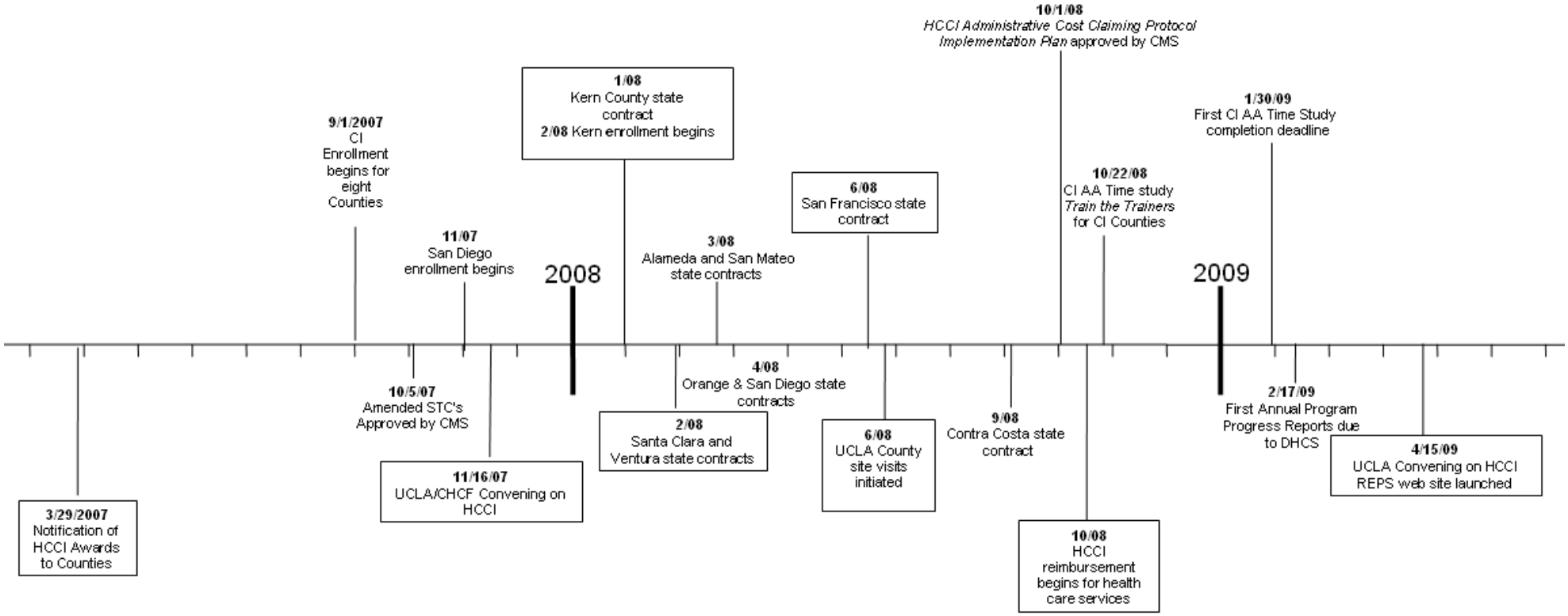
Targeted Service Delivery: Disease Management

The San Diego HCCI program focuses on the populations with diabetes and hypertension. The program targets low-income uninsured individuals who visit emergency rooms or participating community clinics in the county for these conditions and delivers health care services to them. High-risk and high-use individuals are identified and managed intensely. Disease management services are comprehensive and delivered through trained nurses, health educators, and peer educators.

Implementation Timeline and Challenges

Exhibit 23 displays the major milestones in the implementation of the first year of the HCCI program.

Exhibit 23: Timeline of HCCI Program Implementation, March 2007 to April 2009



The timeline of HCCI program implementation shown in Exhibit 23 also identifies several challenges faced by HCCI participating counties in planning, enrollment, and funding. Two of the most significant challenges to implementation were the short amount of time available for program planning and delays in developing reimbursement protocols.

Program Planning

Counties were approved for participation in the HCCI program approximately five months prior to program start date. Notification of awards for the HCCI was provided at the end of March 2007 and the program began on September 1, 2007. Counties were at different levels of preparedness at time of program implementation. Depending on existing systems of care, counties had to establish new networks by contracting with new providers or negotiate new contracts with existing provider networks, or engage in both types of activities. Negotiating new contracts and interactions with existing networks posed challenges specific to the HCCI program such as the need for implementation of extensive and shared data systems that may not have been required in previous collaborations. Several counties were unable to start enrollment in September 2007 due to these factors.

Delays in Reimbursement

Reimbursement for the HCCI program expenditures was delayed during negotiations with CMS over health care and administrative costs. Once reimbursement protocols were approved, reimbursement for health care costs began in October 2008, 14 months after program implementation and enrollment. All counties have begun receiving reimbursement for health care expenditures except for Los Angeles, which is still negotiating a final contract.

Reimbursement for administrative expenditures by HCCI counties has not been received to date. The *California HCCI Administrative Cost Claiming Protocol Implementation Plan* was approved by CMS in October 2008, however the state is still working to obtain CMS' approval regarding certain issues affecting federal payments for counties' expenditures on administrative activities. These issues include:

1) Development of a separate claims computation to capture past administrative costs incurred by counties during the first program year or "prior" period occurring in advance of the first time-study period, which commenced December 2008 – February 2009.
2) Coverage Initiative Percentage (CIP). CIP is intended to address the fact that many counties provide services for both HCCI and non-HCCI eligible individuals; therefore, the allocation of costs must encompass the proportional share of HCCI individuals to the total number of individuals served by the county. Development of the proportional HCCI share, referred to as the "CIP" is necessary to ensure that only the costs related to HCCI eligible individuals are claimed to the HCCI program. Not all program activities are subject to the CIP; e.g., the costs of efforts for outreach and enrolling eligible low-income uninsured individuals into HCCI programs are eligible for reimbursement and are not subject to the CIP discounting. In July 2009, the state sent a revised copy of the *California HCCI Administrative Cost Claiming Protocol Implementation Plan* to stakeholders containing the approved CIP formula that includes a definitional change for

3) County Claiming Plans – the state is currently working with HCCI counties to prepare their CIAA claiming plans as required and outlined within the *California HCCI Administrative Cost Claiming Protocol Implementation Plan.* It is anticipated that county claiming plans will be finalized and approved for most if not all HCCI counties by the end of August 2009.

CONCLUSIONS

The data presented in this interim report indicate that the HCCI program has met a number of its goals in the first year of its implementation. The HCCI program has made progress in improving the health status of low-income uninsured individuals, while strengthening local safety net systems, improving access to care and quality of care, creating efficiencies in health care delivery, and promoting sustainability of HCCI funded programs. Strong evidence exists to demonstrate:

- Expansions in covered services,
- System redesign, and
- Innovations in specialty care and network creation.

Partial evidence exists to demonstrate:

- Improvements in patient outcomes,
- Increased adherence with clinical guidelines, and
- Decreased utilization of inpatient care and ER visits.

No evidence is currently available to demonstrate:

- Cost savings due to improved efficiencies, or
- Sustainability of the HCCI program in the absence of federal financial support.

Implications for Waiver Renewal

1. To encourage innovation, the State should provide clear guidelines for the design of the HCCI program in the next phase, but allow flexibility in implementation of the program.

In its current form, the HCCI program is based on the existing safety-net systems to avoid duplication of multiple systems of care and allow for efficiencies in utilizing the current infrastructure of participating counties. Differences in pre-HCCI county programs often led to diverse strategies to implementation of the HCCI program by each county. In the absence of specific criteria guiding program implementation, county programs differ in focus and subsequent outcomes.

2. Savings may be achievable to sustain HCCI in the future, but a three-year pilot demonstration may be too short to demonstrate such savings.

The HCCI program expanded health care coverage to previously uninsured populations. Pent-up demand for health care for populations lacking access to needed health services, often for the long term, is a well-known phenomenon. The data on health care utilization provided in this report reveals a high level of service use for the program to date and indicates a potentially downward trend in the long term. Overtime, the immediate needs of the newly covered population are addressed and future service utilization primarily consists of maintenance of chronic conditions and delivery of preventive care. Enrollment in and out of the HCCI program

is dependent on income and residence eligibility and is more fluid than traditional health insurance programs. Thus, achievable savings within the first year of program implementation or the full three-year implementation are difficult to attain.

3. Expansion of HCCI state-wide appears feasible based on best practices of the 10 county pilot programs to date.

The HCCI pilot program has paved the way for the feasibility of expansion of the program state-wide in the next phase. A number of significant challenges of the program have been addressed including testing and implementation of reimbursement procedures; overcoming enrollment challenges and barriers; and progress in implementing innovations in care delivery and system redesign. The experiences of the California Department of Health Care Services in administering the program are significant and applicable to the next phase of the program post renewal. The experiences of the participating HCCI counties in implementing the program are vast and replicable in other counties. The diversity of the HCCI participating counties is an added advantage for participation of other California counties who are likely to find strategies that are replicable within their existing systems.